

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 116TH ST CARMEL, IN 46032
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W0000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of survey: May 15, 16, 17, 18, and 21, 2012</p> <p>Facility Number: 000890 Provider Number: 15G376 AIMS Number: 100244260</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/25/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement their neglect policy by neglecting to ensure 1 of 4 sampled clients (client #1's) safety with a heating pad resulting in second degree burns on her back.</p> <p>Findings include:</p> <p>The facility failed to implement their neglect policy by neglecting to prevent client #1 from receiving second degree burns on her back from lying on a heating pad all night. Please see W149.</p> <p>9-3-2(a)</p>	W0122	<p>When the incident occurred, the staff that placed the heating pad was suspended pending an internal investigation. The staff was returned to work and received corrective action as well as retraining on proper procedures for administering a heating pad. In addition, as documented, all staff working at the group home were retrained on 3/28/12 on the proper protocols for the use of cold compresses and heating pads.</p> <p>In addition to all of the steps noted that have already been completed, the Program Nurse will be retrained on the need to ensure that specifics are provided to staff regarding instructions of care and follow up for any medical recommendations when directions are unclear or not specific.</p> <p>Ongoing, the Program Nurse will review all recommendations from medical appointments and ensure that specifics regarding instructions of care and follow up are provided to staff if instructions are unclear and/or not specific. The Program Director will work with the Program Nurse to ensure all staff are trained on any specific procedures for following medical recommendations.</p>	06/20/2012			

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			Responsible Staff: Program Director, Program Nurse, Nursing Supervisor		

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation and interview, the facility failed for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who resided in the group home by locking the door to a storage area where extra food, bathing supplies, and bedspreads were kept.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/15/12 from 4:35 PM to 7:00 PM where clients #1, #2, #3, #4, #5, #6, and #7 resided. There was a door that led out to storage area that was kept locked. In the storage area there were snack foods, extra bathing supplies, and bedspreads.</p> <p>Interview on 5/15/12 at 6:40 PM with client #3 was conducted. Client #3 indicated new bedspreads for client #2 and her were kept in this storage area and all the snack foods. Client #3 indicated none of the clients was allowed in this room. She indicated she did not have a key to this door and none of the clients did, only the staff. Client #3 indicated it</p>	W0125	<p>All consumers, including Client #3 had bedspreads on their beds. The extra bedspreads in the storage area were purchased on sale for future use. All food and cleaning supplies that the clients need are kept available inside the group home and are unsecured for consumers to access. Those items purchased in excess in order to ensure supplies are available as needed are stored in the garage area. The garage door is locked in order to protect confidential client historical documentation that is also stored in this area.</p> <p>Responsible Staff: Home Manager, Program Director</p>	06/20/2012			

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	<p>is locked up because of clients #2 and #6.</p> <p>Interview on 5/15/12 at 6:50 PM with staff #1 was conducted. Staff #1 indicated only staff have the key to that storage area, not clients. He stated it was locked "to keep clients out of there, to get them what they need, not what they want to get." He indicated none of the clients would go in and take all the food. He indicated the key is kept in the med box locked up.</p> <p>Interview on 5/16/12 at 7:20 AM with staff #2 was conducted. Staff #2 indicated they didn't want anyone going in there (the storage area). She indicated the surplus food that doesn't fit in the cabinets, cleaning supplies, summer clothes, toilet paper, paper towels, and trash bags were kept in the locked storage area.</p> <p>Interview on 5/16/12 at 12:20 PM with the AD (Area Director) was conducted. The AD indicated she did not know the door to the storage area was locked. The AD indicated there was nothing in that room the clients shouldn't have access to.</p> <p>9-3-2(a)</p>						

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 1 of 3 allegations of staff neglect reviewed for 1 of 4 sampled clients (client #1), the facility neglected to implement their policy to prevent client #1 from getting burned by a heating pad.</p> <p>Findings include:</p> <p>Review on 5/15/12 at 2:10 PM of the facility BDDS (Bureau of Developmental Disabilities Services) incident reports was conducted. One incident report dated 3/15/12 indicated staff #4 was instructed to place a heating pad under client #1's back per doctor's order. The heating pad was covered and was not placed directly on her skin when she went to bed. When she woke up, she had burn blisters on her back from the heating pad. She was taken to the ER (Emergency Room) and was treated with cream and dressing for her burns. Staff was instructed not to leave a heating pad on clients no longer than 10 to 15 minutes. The investigation for this incident dated 3/19/12 indicated the following:</p> <p>Staff #4 indicated client #1 had fallen on 3/12/12 which caused bruising. Client #1</p>	W0149	<p>When the incident occurred, the staff that placed the heating pad was suspended pending an internal investigation. The staff was returned to work and received corrective action as well as retraining on proper procedures for administering a heating pad. In addition, as documented, all staff working at the group home were retrained on 3/28/12 on the proper protocols for the use of cold compresses and heating pads.</p> <p>In addition to all of the steps noted that have already been completed, the Program Nurse will be retrained on the need to ensure that specifics are provided to staff regarding instructions of care and follow up for any medical recommendations when directions are unclear or not specific.</p> <p>Ongoing, the Program Nurse will review all recommendations from medical appointments and ensure that specifics regarding instructions of care and follow up are provided to staff if instructions are unclear and/or not specific. The Program Director will work with the Program Nurse to ensure all staff are trained on any specific procedures for following</p>	06/20/2012	

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	<p>complained of back pain. On 3/13/12, client #1 was taken to the doctor due to her complaints of back pain. The doctor recommended the use of a heating pad or pack and Tylenol every 4 hours for pain as needed. Staff #4 indicated there were no specific directions provided regarding the use of the heating pad. Staff #4 plugged in client #1's heating pad and placed it at the foot of client #1's bed before she left her shift at 9 PM on 3/14/12. The heating pad was not turned on at that time. Staff #2 worked the morning shift on 3/15/12 and discovered, along with staff #5, a "huge red mark with a blister and pustules."</p> <p>The investigation interview with staff #5 indicated client #1 went to bed on 3/14/12 after 9 PM and she had asked staff #4 to get the heating pad ready before she left her shift at 9:00 PM. Staff #5 entered client #1's room between 11:00-11:30 pm to take the heating pad off and offer client #1 Tylenol. Client #1 did not want any Tylenol and was sleeping on her back. Staff #5 checked on client #1 again between 2:00-2:30 AM. Client #1 asked for the heating pad back but still did not want any Tylenol. Staff #5 checked the setting on the heating pad to ensure it was on low. Staff #5 did not see client #1 again until after staff #2 reported to work and asked her to assess client #1 with her.</p>		<p>medical recommendations.</p> <p>Responsible Staff: Program Director, Program Nurse, Nursing Supervisor</p>				

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	<p>Staff #5 indicated she initially observed what she thought was just a pink area where client #1 had slept until she looked closer and observed small blisters. The nurse was called and instructed staff #5 to place a cold rag on the area. Staff #5 and staff #2 applied cold compresses to the area but the area continued to look worse. The house manager assessed client #1 when she arrived at the group home on 3/15/12 and observed 6 small blisters about 1 inch long and 1/2 inch wide.</p> <p>The conclusion on the investigation indicated "Evidence supports [client #1] received a burn from a heating pad as a result of staff failing to monitor the use of the heating pad."</p> <p>Review on 5/15/12 at 2:10 PM of the facility's abuse/neglect policy dated April 2011 indicated: "Indiana MENTOR promotes a high quality of service and seeks to protect individuals, receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." It indicated alleged neglect could include "Failure to provide appropriate supervision, care or training."</p>						

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	<p>Interview on 5/16/12 at 1:05 PM with the nurse was conducted. The nurse indicated with client #1's age and dry skin, the heating pad wouldn't have to be on high to cause burns. The nurse discussed this at a staff meeting with the staff after the 3/15/12 incident that the heating pad can cause burns in a short amount of time on a low/medium setting.</p> <p>Interview on 5/17/12 at 9:55 AM with the nurse was conducted. The nurse indicated client #1 received second degree burns from the heating pad.</p> <p>Review on 5/21/12 at 3:15 PM of the staff training record dated 3/28/12 indicated all staff were trained on the protocol for the use of cold compresses and heating pads.</p> <p>9-3-2(a)</p>						

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) to obtain written consent for her Behavior Support Plan.</p> <p>Findings include:</p> <p>Review on 5/16/12 at 11:10 AM of client #3's records was conducted. Client #3's Behavior Developmental Plan dated 2/23/12, included two anti-depressant meds: one 40 milligram Paxil and one 75 milligram Nortriptylin. The Human Rights Committee (HRC) reviewed and approved her plan on 3/7/12. Client #3, who was emancipated, did not give her written consent.</p> <p>Interview on 5/16/12 at 12:55 PM with the AD (Area Director) was conducted. The AD indicated there was no written consent from client #3 for her behavior plan.</p> <p>9-3-4(a)</p>	W0263	<p>Client #3 has provided consent for her Behavior Development Plan.</p> <p>The Program Director will receive retraining to ensure that all emancipated consumers and/or their guardians have provided consent for any new or updated behavior plans prior to them being reviewed by the Human Rights Committee.</p> <p>The Human Rights Committee members will receive retraining to ensure that all emancipated consumers and/or their guardians have provided consent for any new or updated behavior plans prior to them being reviewed by the Human Rights Committee.</p> <p>Ongoing the Area Director will review all HRC reports submitted at least quarterly to ensure that all consumer and/or guardians have approved any new or updated behavior plans prior to them being reviewed by the Human Rights Committee.</p> <p>Responsible Staff: Program Director, Area Director, Human Rights Committee members</p>	06/20/2012	

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed to administer without error one medication out of three for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/15/12 from 4:35 PM to 7:00 PM. At 5:11 PM, client #1 was administered one 20 mg (milligrams) Prilosec tablet (for stomach) by staff #3. The pill packet indicated it was to be taken 30 minutes before evening meal. Client #1 started eating dinner at 5:20 PM.</p> <p>Review on 5/15/12 at 6:10 PM of client #1's Physician's Order dated 3/2/12 indicated client #1 was to take one Prilosec (also known as Omeprazole) 20 mg tablet by mouth 30 minutes before evening meal. Client #1's MAR (Medication Administration Record) dated 5/15/12 indicated Prilosec was to be taken 30 minutes before evening meal.</p> <p>Interview on 5/16/12 at 12:55 PM with the Nurse was conducted. The nurse</p>	W0369	<p>All staff will receive retraining on all consumers medication orders including Client #1 Prilosec needing to be given 30 minutes prior to a meal.</p> <p>Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following all consumers medication orders as written.</p> <p>Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following all consumers medication orders as written.</p> <p>Responsible staff: Home Manager, Program Director</p>	06/20/2012			

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	indicated client #1's Prilosec should have been given 30 minutes before client #1 ate dinner. 9-3-6(a)				

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W0440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who resided in the group home by not conducting evacuation drills at least one per shift per quarter, or every 90 days, in the past year.</p> <p>Findings include:</p> <p>Review on 5/15/12 at 2:45 PM of the facility's evacuation drills was conducted for the period of 6/1/11 to 5/15/12 for clients #1, #2, #3, #4, #5, #6, #7 and #8. During first shift (6:00 AM to 2:00 PM), there were two drills run in October 2011, and none after that. During second shift (2:00 PM to 10:00 PM), there was one run on 7/17/11 and none after that.</p> <p>Interview on 5/16/12 at 12:35 PM with the AD (Area Director) was conducted. The AD indicated evacuation drills were to be conducted every month, and one per shift per quarter.</p> <p>9-3-7(a)</p>	W0440	<p>All Direct Support Professionals will receive a retraining at least every other month to ensure that they understand the importance of completing the monthly fire drills. The training will include reviewing a copy of the fire drill schedule.</p> <p>Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met.</p> <p>Ongoing, the completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p> <p>Responsible Staff: Home Manager, Program Director, Quality Assurance</p>	06/20/2012	